



Dokiman siplemantè DEMANND POU BAY TRETMAN DOKTÈ REKÒMANDE (SE PA POU BAY MEDIKAMAN)

Fòm preskripsyon doktè pou bay tretman | Biwo sante lekòl | Ane lekòl 2021-2022

Tanpri voye l tounen ba enfimye lekòl la. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la.

Siyati elèv la: _____ Non: _____ Dezyèm non: _____
Dat nesans: _____ Sèks: Gason Fi Nimewo OSIS: _____ Klas: _____ Salklas: _____
Distri DOE: _____ Lekòl (mete ATSDBN non, nimewo, adrès ak borough)

HEALTHCARE PRACTITIONERS COMPLETE BELOW

ONE ORDER PER FORM (make copies of this form for additional orders). Attach prescription(s) / additional sheet(s) if necessary to provide requested information and medical authorization.

- | | | |
|--|--|--|
| <input type="checkbox"/> Blood Pressure Monitoring | <input type="checkbox"/> Feeding Tube replacement if dislodged - specify in #5 | <input type="checkbox"/> Trach Replacement - specify in #5 |
| <input type="checkbox"/> Chest Clapping/Percussion | <input type="checkbox"/> Oral / Pharyngeal Suctioning: Cath Size _____ Fr. | <input type="checkbox"/> Vagus Nerve Stimulator |
| <input type="checkbox"/> Clean Intermittent Catheterization: Cath Size _____ Fr. | <input type="checkbox"/> Ostomy Care | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Central Line | <input type="checkbox"/> Oxygen Administration - specify in #2 | |
| <input type="checkbox"/> Dressing Change | <input type="checkbox"/> Postural Drainage | |
| <input type="checkbox"/> Feeding: Cath Size _____ Fr. | <input type="checkbox"/> Pulse Oximetry monitoring | |
| <input type="checkbox"/> Nasogastric <input type="checkbox"/> G-Tube <input type="checkbox"/> J-Tube | <input type="checkbox"/> Trach Care: Trach. Size _____ | |
| <input type="checkbox"/> Bolus <input type="checkbox"/> Pump <input type="checkbox"/> Gravity <input type="checkbox"/> Spec./Non-Standard* | <input type="checkbox"/> Trach Suctioning: Cath Size _____ Fr. | |

Student will also require treatment: during transport on school-sponsored trips during afterschool programs

Student Skill Level (Select the most appropriate option):

- Nurse-Dependent Student: nurse must administer treatment
- Supervised Student: student self-treats under adult supervision
- Independent Student: student is self-carry/self-treat (initial below)

I attest student demonstrated the ability to self-administer the prescribed treatment effectively during school, field trips, and school-sponsored events

Practitioner's initials

Diagnosis: _____ **Enter ICD-10 Codes and Conditions (RELATED TO THE DIAGNOSIS)**
Diagnosis is self-limited: Yes No _____ _____ _____

1. Treatment required in school:

Feeding: Formula Name: _____ Concentration: _____
Route: _____ Amount/Rate: _____ Duration: _____ Frequency/specific time(s) of administration: _____

Premixing of medications and feedings by parents is no longer permissible for a nurse to administer. Nurses may prepare and mix medications and feedings for administration via G-tube as ordered by the child's primary medical provider.

Flush with _____ mL _____ Before feeding After feeding
 Oxygen Administration: Amount (L): _____ Route: _____ Frequency/specific time(s) of administration: _____
 prn O2 Sat < _____ % Specify signs & symptoms: _____

Other Treatment: Treatment Name: _____ Route: _____ Frequency/specific time(s) of administration: _____
Specify signs & symptoms: _____

Additional Instructions or Treatment:

2. Conditions under which treatment should not be provided:

3. Possible side effects/adverse reactions to treatment:

4. Emergency Treatment: Provide specific instructions for nurse (if one is assigned and present) in case of emergency, including adversereactions, including dislodgement or blockage of tracheostomy, or feeding tube:

5. Specific instructions for non-medical school personnel in case of adverse reactions, including dislodgement of tracheostomy or feeding tube:

6. Date(s) when treatment should be: Initiated: _____ Terminated: _____

Health Care Practitioner

Last Name: _____ First Name: _____ MD DO NP PA
Address: _____
Tel. No: _____ Fax No: _____ Cell phone: _____ Email: _____
NYS License No (Required): _____ NPI No _____ Date: _____
Practitioner's Signature: _____

DEMANND POU TRETMAN DOKTÈ REKÒMANDE (SE PA POU BAY MEDIKAMAN)

Fòm preskripsyon doktè pou bay tretman | Biwo sante lekòl | Ane lekòl 2021-2022
Tanpri voye l tounen ba enfimye lekòl la. Fòm yo resevwa apre 1ye jen ka retade pwosesis la pou nouvo ane lekòl la.

PARAN/RESPONSAB LI, RANPLI AK SIYEN: LÈ M SIYEN PI BA A, MWEN DAKÒ AVÈK BAGAY SA YO:

- Mwen dakò pou yo konsève medikaman pitit mwen ak ba li yo nan lekòl la dapre eksplikasyon doktè/founisè swen sante pitit mwen an bay.
- Mwen konprann ke:
 - Mwen dwe bay enfimye lekòl la materyèl, ekipman ak tretman medikal pitit mwen an.
 - Tout materyèl mwen bay lekòl la fèt pou nèf, kachte nan bwat oswa boutèt orijinal la. M ap bay lekòl la ekipman ki resan, ki pa ekspire pou pitit mwen itilize pandan jounen lekòl la.**
 - Materyèl, ekipman ak tretman yo dwe make ak non, dat nesans pitit mwen an sou yo.
 - Mwen dwe di enfimye lekòl la imedyatman nenpòt chanjman ki genyen nan tretman pitit mwen an oswa nan eksplikasyon doktè/founisè k ap bay swen k ap trete l la.
 - Biwo sante nan lekòl (Office of School Health, OSH) ak ajan li ki patisipe nan ofri pitit mwen an sèvis sante ki pi wo yo konte sou prezizyon ki nan enfòmasyon ki sou fòm sa a.
 - Lè m siyen fòm sa a, mwen otorize OSH pou bay pitit mwen an sèvis sante. Sèvis sa yo ka genyen ladan pami lòt, yon evalyasyon klinik oswa yon konsiltasyon medikal yon doktè oswa yon enfimye OSH fè.
 - Lòd/eksplikasyon pou bay tretman ki sou fòm sa a ekspire nan fen ane lekòl pitit mwen an, ki ka gen ladan tou sesyon ete, oswa lè mwen bay enfimye lekòl la yon nouvo fòm MAF(kèlkeswa sa ki rive avan an). Lè preskripsyon medikaman sa a ekspire, m ap bay enfimye lekòl pitit mwen an yon nouvo fòm MAF ke doktè pitit mwen an ap ekri. OSH pa p bezwen siyati m pou l ekri lòt fòm MAF alavni.
 - Fòm sa a reprezante konsantman m ak demand mwen fè pou sèvis medikal yo dekri sou fòm sa a. Se pa yon akò OSH genyen pou li bay sèvis ou mande a. Si OSH decide bay sèvis sa yo, pitit mwen an bezwen tou yon Plan akomodasyon pou elèv. Se lekòl la k ap ranpli plan sa a.
 - Nan objektif pou bay pitit mwen an swen oswa tretman, OSH ka gen nenpòt lòt enfòmasyon yo panse ki nesèsè sou pwoblèm medikal pitit mwen an, medikaman l ap pran oswa tretman l suiv. OSH ka pran enfòmasyon sa a nan men nenpòt doktè, enfimye oswa famasyen ki bay pitit mwen an sèvis.

POU ELÈV KI KA PRAN MEDIKAMN POUKONT YO (ELÈV KI ENDEPANDAN SÈLMAN)

- Mwen sètifye/konfime pitit mwen an resevwa bon jan trening epi li kapab fè tretman yo poukont li. Mwen dakò pou pitit mwen an pote, konsève ak fè poukont li tretman yo preskri nan fòm sa a nan lekòl la. Mwen gen responsablite pou bay pitit mwen an materyèl ak ekipman sa yo ak etikèt, jan yo dekri sa pi wo a. Mwen gen responsablite tou pou m sipèvizè tretman pitit mwen an ak pou tout konsekans ki genyen nan bay tèt li tretman poukont li. Enfimye lekòl la pral konfime kapasite pitit mwen an pou l fè tretman poukont li. Mwen dakò tou pou bay lekòl la ekipman oswa materyèl "an rezèv" ki make byen klè sizoka pitit mwen an pa ka bay tèt li tretman poukont li.

Yo pa pèmèt ankò pou enfimye bay medikaman oswa manje paran fin melanje. Enfimye ka prepare ak melanje medikaman ak manje pou yo bay nan G-tube jan doktè fanmi an rekòmande l la.

Siyati elèv la: _____ Non: _____ Inisyal dezyèm non: Dat nesans: _____

Non/ATSDBN lekòl la _____

Borough: _____ Distri: _____

Imèl paran/responsab la: _____ Adrès Paran/Responsab: _____

Nimewo telefòn: Lajounen: _____ Lakay: _____ Selilè*: _____

Non paran/responsab: _____ Siyati paran/responsab: _____ Dat fòm lan siyen: _____

Lòt non moun nou ka kontakte lè gen ijans:

Non: _____ Relasyon l avèk elèv la: _____ Nimewo pou kontakte l: _____

For Office of School Health (OSH) Use Only / Plas sa a rezève pou Biwo OSH sèlman

OSIS Number: _____

Received by: Name: _____ Date: _____ Reviewed by: _____ Date: _____

504 IEP Other Referred to School 504 Coordinator: Yes No

Services provided by: Nurse/NP OSH Public Health Advisor (For supervised students only) School Based Health Center

Signature and Title (RN OR SMD): _____ Date School Notified & Form Sent to DOE Liaison: _____

Revisions as per OSH contact with prescribing health care practitioner: Clarified Modified

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*Confidential information should not be sent by e-mail.